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ANDOVER RURAL DISTRICT COUNCIL

Annual Report

OF THE

Medical Officer of Health

For the Year 1951

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The Standard Press (Andover) Ltd.

PUBLIC HEALTH OFFICERS

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TO THE CHAIRMAN AND MEMBERS OF THE ANDOVER RURAL DISTRICT COUNCIL

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report for the year 1951.

Once a year the Medical Officer of Health is given the opportunity in his Annual Report of expressing his views on the state of the Public Health not only in his own community but over the wider field, and this opportunity is one which many Medical Officers of Health value highly. It may be that the small attention which may be paid locally to his report means that its result is more to marshal and clarify his own thoughts than anything else, but even that is of value.

It has been said that it takes 30 years from the time a problem and its solution are seen by the few for that problem to be seen by the many, and the solution applied. Consequently the basic problems do not change from year to year and this is as true of the Public Health as of any other field. The report of a Medical Officer of Health, so far as his views on the Public Health are concerned, is therefore bound to show little change from year to year.

The central problem of the Health Services is still exactly as I represented it a year ago and there is no sign of any attempt to apply the remedy. So long as we try to achieve health by treating disease so long must we expect to spend an increasing proportion of our national income on the treatment of disease, for the increase in scientific knowledge is something which will continue at an accelerating rate and the cost of the treatment of disease will increase as research and therapeutics become even more elaborate and expensive. Sooner or later we will realise that we cannot afford to treat the sick, and that we must keep people well.

Our deteriorating economic position is due to external circumstances over which we have no control and the deterioration can be expected to continue. Consequently the necessity for appreciation of the cost of therapeutic medicine is becoming more and more important not only so that the whole policy may be changed but also so that a limit may be agreed beyond which the cost of disease treatment must not increase. The pressure of sheer economic necessity will force the collapse of the present policy.

In 1947 21.4% of the population of England and Wales were aged under 15, 37.4% were aged 15-40, 30.7% were aged 41-64, and 10.5% were aged over 64. In 1962 20.7% will be aged under 15, 33.5% will be aged 15-40, 33.3% will be aged 41-64, and 12.5% will be aged over 64. In 1977 19.2% will be aged under 15, 33.8% will be aged 15-40, 30.8% will be aged 41-64, and

16.2% will be aged over 64*. So the proportion of dependants increases while that of producers falls, and among both dependants and producers the proportion of those most likely to be sick increases (the old in the case of dependants, the older working age group in the case of producers) while the proportion of those least likely to be sick decreases (the young in the case of dependants, the younger working age group in the case of producers) and if we are going to go on trying to achieve health by treating sickness we can certainly expect an increase in the demand. For example since 75% of mental patients are 65 or over, it follows that by 1977 the number of patients will have increased by 47%.

A memorandum which must be viewed in the light of our limited economic resources was issued by the Ministry of Health in 1950†. This document purported to indicate to regional hospital boards what was expected of them in the way of provision of specialist services, but as far as can be seen the planners simply accepted without question the extravagant demands put forward by each speciality. They did not investigate the reasonableness of these, nor did they estimate what they would mean to the country when taken together. Dr. Ffrangcon Roberts of Cambridge whom I have quoted before, and will no doubt quote again, has made this calculation‡ from the figures contained in the report. According to his estimate it would be necessary, in order to satisfy these demands, to increase the number of hospital beds from 476,000 on 31 Dec., 49 to 755,000 or by 63%, and the number of whole-time consultants from 5,000 to 11,000 or by 120%. Dr. Roberts has calculated from the figures for hospital beds that in order to fill these it will be necessary for one in seven of the community to do his duty by spending 18 days in a general hospital each year. So much, as Dr. Roberts says for a healthy nation. The total hospital staff including non-medical personnel came to 220,000 on 31 Dec., 49, and if the additional 63% of beds were forthcoming, hospital personnel would have to be increased by 140,000 to 360,000. These 360,000 would come from among the very best of our diminishing labour force, and would be engaged in non-productive employment. The truth is that the authors of this document live in a dream world of their own. As Dr. Roberts says, the Ministry of Health want the consultant services to go to plenty in the midst of poverty: to a medical heaven in the midst of a bankrupt, bedridden, and hungry hell.

At this point it may be of interest to show what is happening to the Health Service estimates from year to year§. Whereas in 1950-51 the Hospital Boards were responsible for 59.6% of the total expenditure, in 1951-52 they were responsible for 62.9%, and in 1952-53 they are expected to be responsible for 68.6%. As a stop-gap measure the Government have decided to make a charge for the pharmaceutical, dental and supplementary ophthalmic services, cutting these down from 25.2% of the total in 1950-51 to 21.7% in 1951-52, and 15.4% in 1952-53, but it will be seen that this saving disappears into the ever-willing maw of the hospital services, for the combined total of the two for the three years is 84.8%, 84.6%, and 84.0% of the total for the health services. There is a limit to the extent to which one branch of the therapeutic service can be raided to support another, and the hospital service which already takes more than two thirds of the money available cannot be kept going in this manner much longer. As the special correspondent who wrote this article on the Health Service Costs says, expenditure on hospitals could be expanded indefinitely.

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* Report of the Royal Commission on Population 1949.

† The Development of the Consultant Services.

‡ British Medical Journal 1952, I, 321.

§ British Medical Journal 1952, I, 759.

Health cannot be achieved by having more hospitals, any more than good cars can be produced by having more repair shops. A manufacturer of motor cars, faced with a defective component in one of his products, would not put up a factory to mend or replace the components. He would find out what was wrong with it and turn out better ones in future. Dr. Roberts realises that Nature is infinitely complex, and that further research into disease and treatment will only disclose ever-widening fields, but his suggestion is that we should develop some system of priorities, when treatment would be provided in proportion to the recipient's ability to return, in the form of service, its cost to the community. This prospect is one which must be repugnant to all who have any humanitarian instinct, but I believe firmly that it is one which will inevitably be forced upon us if we continue with our present policy. If we have only so much to spend on the treatment of the sick we are obviously going to spend it where there is some return, and we cannot go on spending more and more of our total resources in this way. It is not only the materials which go into it, it is the manpower as well.

There is however, another answer to this problem than that of allocating treatment only where there will be a corresponding return. The doctrine of original disease has come to be accepted by Man, and it never occurs to us to question whether Nature might not have meant us to be healthy. We accept sickness and disease as inevitable and devote our medical services almost entirely to their investigation and treatment. We never stop to question why the incidence of disease is so different in different countries, or even in different parts of the same country. Stocks* in his studies of statistics in England and Wales discovered that for cancer there is a difference of incidence, according to system and organ, among various areas of the same country, and Pascua* has found that there is a similar difference of incidence in different countries. Mellanby† reports that there is almost a complete absence of disseminated sclerosis among the South African born white population, and that the incidence of alimentary disorders among the natives of tropical and subtropical countries is much smaller than in Western Europe and America.

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* Stocks P. Regional and Local Differences in Cancer Death Rates. General Register Office 1947.

Our research should be into health and its attainment, not into disease and its treatment. The treatment of a disease in one individual does nothing to prevent another from acquiring the same condition, nor even to prevent the first from becoming ill again when he returns to the environment (which in its broad sense includes food) which made him take ill in the beginning. It may be argued that such research will be as complex and unrewarding as is our present research. But I believe that what we are going to find in every case is that it was where we went astray from Nature that we were wrong, and that it is only in the direction of aberrations from Nature that we need look for the cause of disease.

Meantime we spend (1951-52) £274.3 million (62.9%) on the Hospital Service, £142.8 million (32.8%) on the Executive Councils (responsible for general practitioner, pharmaceutical, dental and supplementary ophthalmic services) and £18.6 million (4.3%) on the Local Health Authorities. Just think of it! £417.1 million, or 95.7 per cent for the treatment of disease. £18.6 million, or 4.3 per cent for the promotion of health.

HOUSING—

No excuse is needed for including some words on Housing. The Housing problem is still the most serious matter affecting the health of the community and as far as can be seen there is every prospect that this situation will continue indefinitely. 172,000 houses were built in England and Wales in 1951 which is exactly the same number as in 1950. I repeat once more that this is exactly half the figure for 1938 (344,000), and that it is less than the number required for replacements (182,000). As a result, the lists of prospective tenants for Council houses continue steadily to increase.

There is no fair way of allocating houses when the number of houses available is less than the number of people who need them. It is impossible to estimate in numerical terms the relative severity of the housing positions of the different applicants and a points scheme however carefully prepared, cannot do more than bring forward the names of those who should be considered next. It is sometimes said that those who have no place of their own should at all times be considered before those who do have a home however unsatisfactory, but this view can perhaps be carried too far. It is seldom satisfactory for a young couple to live with in-laws, but a sub-let where the geography of the house is reasonably good may be a great deal better than ex-Services huts and houses which come under the category of fit for condemnation only.

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* Epidemiological and Vital Statistics Report of the World Health Organisation, January, February, 1952.

† British Medical Journal, 1951, II, 865.

There are at present in occupation in this Rural District 179 ex-Services huts and the Hobhouse Survey disclosed that 289 houses were unfit and unsuitable for reconditioning. It is now more than six years since the end of the war, and many of these huts are no longer fit to live in. At the same time the 289 unfit houses are deteriorating and the question arises as to how much longer people can be expected to live in some of them, even if they do not actually become dangerous or fall down. My own view is that it is becoming necessary to rehouse some of the tenants of both huts and houses. The possibility of setting a definite limit to the date at which all these tenants should be rehoused, and of rehousing the appropriate proportion each year might be considered. This would perhaps be too inelastic, but it would at least provide some sort of a guide as to how many to rehouse each year.

Another question which I should like to discuss is that of allocation of houses to childless couples and those whose families have grown up and left home. On the one hand it is so much easier for a childless couple to obtain accommodation than it is for one with a family, that it is easy to understand those who say that all houses should go to couples with families; on the other a certain proportion of marriages result in involuntary childlessness and it seems hard that those who want a family and a home should be denied the latter because they cannot have the former. My own view is that a childless couple or one whose family have grown up and left home should be allocated a house only when this results in releasing a suitable home for a couple with a family and that the house they are allocated should be one not suitable for a family. One example would be a childless couple or one whose family have grown up and left home living in a privately owned house which is too big for them and where the landlord is willing to rent it to a couple with a family, and this would also apply to a couple whose family had grown up and left home and who were underoccupying a council house. In my opinion all cases of under-occupation should be dealt with by transferring the tenants to cottages (a much more attractive term than bungalows) whether they request to be transferred or not. The council should pay the removal expenses and the rent of the new house should not be more than that of the old. This procedure is a method whereby the council can provide a family with a house at the cost of building a cottage. Again, my own view is that such cottages should only be built where a house, whether publicly or privately owned, is to be released for a family thereby.

There has been a good deal of talk recently on lowering standards for new houses so that more houses may be built. Now there is no doubt that some of the houses built since the war have been extravagant in some respects, as for example ceiling height and the provision of an extra lavatory (which in any case has not contained a wash basin and is therefore quite wrong) but we must be careful that in reducing standards we do not reduce below what is needed. We have come to accept that a couple with a family need a house with a kitchen, sitting room, bathroom, and three bedrooms, and I hope we will not depart from that standard. It is better to build fewer houses than to build substandard ones. Insofar as our housing problem is partly due to overcrowding, any building of houses which have a reduced number of rooms will only perpetuate that overcrowding.

The trouble is that there are in this country 20,000,000 people whom we cannot feed, and that we must import the food to feed these people, and the raw materials to manufacture into exports to sell to buy that food, while those countries from whom we obtain our food and raw materials are developing their own industries and becoming more and more independent of our exports, so that all the time we are asked more for our imports and offered less for our exports, and an ever increasing proportion of our total production has to go for export as the amount we have to send abroad is increasing more quickly than is our total production. So there is less left for us at home, and we find we can no longer afford for example, the houses, the clothes, or the railway journeys to which we have been accustomed. This is a trend which it appears inevitable will continue, and it would be better if the politicians would cease to offer us (under the aegis of their own party) a future which it is not within their power to grant and would confess frankly that shortages of all kinds, including housing will not improve and may get worse, so that individuals and families may make up their own minds what to do. Many would choose to remain. This is still the most beautiful country in the world, the one with the highest standard of integrity in its central and local government, and the one with the best climate in the world (with the exception of New Zealand). But many others would choose to go to the Dominions which cannot in any case develop their proved resources because they do not have the people to develop them.

Finally, it may be of interest to compare the number of houses built in Andover Rural District (population 14,900) since the end of the war with the number which might have been expected had houses been built at the same rate as in all Rural Districts (population 8,068,309). 157,036 permanent houses were built by public and 39,342 by private enterprise and 9,998 temporary houses were built by public enterprise (total 206,376) up to the end of 1951 and on that basis 290 permanent houses might have been built by public and 73 by private enterprise and 18 temporary houses might have been built by public enterprise (total 381) in Andover Rural District. The actual figures were 319 permanent houses built by public and 89 by private enterprise and 32 temporary houses built by public enterprise (total 440) giving 110%, 122%, 178% and 115% respectively of what might have been expected.

The figures for 1951 alone however are not so satisfactory. 33,706 permanent houses were built by public and 4,950 by private enterprise (total 38,656) and on that basis 62 permanent houses might have been built by public and 9 by private enterprise (total 71) in Andover Rural District. The actual figures were 56 permanent houses built by public and 9 by private enterprise (total 65) giving 90%, 100% and 92% respectively of what might have been expected. Such a deficiency for one year for one authority might easily be explained on the basis of difficulties with individual contracts, and a below average year might well be followed by an above average year, but the other two authorities for which I am Medical Officer of Health, which had also hitherto been up to average, have also had a below average year, and this suggests the possible existence of some adverse factor in this area. Perhaps the answer is to make more use than hitherto of prefabricated permanent houses.

I am indebted to Mr. R. J. Richards, A.I.A.S., M.R.San.I., M.S.I.A., Chief Sanitary Inspector, for his assistance in the preparation of this report (Sections C, D and E).

I have the honour to be,

Mr. Chairman, Ladies and Gentlemen,

Your obedient servant,

JOHN SLEIGH.

SECTION A

STATISTICS AND SOCIAL CONDITIONS OF THE AREA

(1950 figures in brackets)

Area (in acres)	67,811	(67,811)
Registrar General's estimate of resident population	17,590	(14,900)
Number of inhabited houses according to Rate Books	3,734	(3,670)
Rateable Value	£91,872	(£88,664)
Sum represented by a Penny Rate	£383	(£369)

Chief Industries in the area :

Below are given Ministry of National Insurance figures of numbers employed, obtained from the Ministry of Labour. It is not possible to give figures for the Rural District of Andover as Ministry of National Insurance areas are based not on existing Local Government areas but on the towns and the areas of country draining naturally into them. The figures given are for the area of the Andover office of the Ministry of National Insurance, which area comprises :

Andover Municipal Borough
Andover Rural District

Hurstbourne Priors, Laverstoke, St. Mary Bourne, Whitchurch, and Portals only in Overton, in Kingsclere and Whitchurch Rural District. Broughton, Houghton, Leckford, Longstock, Nether Wallop, Over Wallop, and Stockbridge, in Romsey and Stockbridge Rural District.

Agriculture	2,000
Paper making and Printing	1,600
Local and National Government	1,400
Building	1,300
Distributive Trades	1,100
Engineering, Garages etc.	1,100
Food and Drink etc.	500
Woodwork, etc.	500
Transport	350
Professions	180
All others	1,670
Total	11,700

Extent of Unemployment

This is virtually non-existent, being 0.1% (England and Wales 1.4%)

VITAL STATISTICS

(1950 figures in brackets)

	Andover R. D.		England and Wales	
Births :	Rates per 1000 Home Population			
Live Births	17.1	(20.9)	15.5	(15.8)
Still Births	0.40	(0.20)	0.36	(0.37)
Deaths :				
All causes	8.1	(7.8)	12.5	(11.6)
Typhoid and paratyphoid	0.00	(0.00)	0.00	(0.00)
Whooping cough	0.00	(0.00)	0.01	(0.01)
Diphtheria	0.00	(0.00)	0.00	(0.00)
Tuberculosis	0.17	(0.07)	0.31	(0.36)
Influenza	0.00	(0.00)	0.38	(0.10)
Smallpox	0.00	(0.00)	0.00	(—)
Acute poliomyelitis (including polioencephalitis)	0.06	(0.00)	0.00	(0.02)
Pneumonia	0.45	(0.20)	0.61	(0.46)
Notifications (Corrected) :				
Typhoid Fever	0.00	(0.00)	0.00	(0.00)
Paratyphoid Fever	0.00	(0.00)	0.02	(0.01)
Meningococcal Infection	0.00	(0.00)	0.03	(0.03)
Scarlet Fever	0.91	(1.21)	1.11	(1.50)
Whooping Cough	2.05	(0.47)	3.87	(3.60)
Diphtheria	0.00	(0.00)	0.02	(0.02)
Erysipelas	0.00	(0.07)	0.14	(0.17)
Smallpox	0.00	(0.00)	0.00	(0.00)
Measles	17.79	(2.01)	14.07	(8.39)
Pneumonia	0.06	(0.07)	0.99	(0.70)
Acute Poliomyelitis (including Polioencephalitis)				
Paralytic	0.00	(0.13)	0.03	(0.13)
Non-paralytic	0.00	(0.00)	0.02	(0.05)
Food Poisoning	0.00	(0.00)	0.13	(0.17)
Deaths :	Rates per 1000 Live Births			
All causes under 1 year of age	33.2	(16.1)	29.6	(29.8)
Enteritis and diarrhoea under 2 years of age			1.4	(1.9)
Notifications (Corrected) :	Total Rates per 1000 (Live and Still) Births			
Puerperal fever and pyrexia	3.25	(0.00)	10.66	(5.81)

VITAL STATISTICS

Birth Rate:

The Birth Rate for 1951 (17.1 per 1000) was 1.6 per 1000 above that for England and Wales (15.5 per 1000). The most important factor affecting the birth rate in one area as compared with that in the country as a whole is opportunity for marriage as the number of babies born in any one family depends more on the age of marriage of the parents than on any other factor. The suggestion is therefore that there is some influence in Andover Rural District advancing the date of marriage. Unemployment is nil which is likely to be one factor and the only other factor that suggests itself is the presence in the district of large numbers of young men in the forces, etc. I do not think that the birth rate even in this district is adequate for replacement purposes.

However, we should not forget that the birth rate for England and Wales is itself well below replacement level. On the basis of current mortality experience only about three quarters of the children needed to maintain the population at its present level are being born. The population is still increasing as a result of the increased expectation of life, but this cannot be expected to continue for we are now at the stage when nearly all will die of old age, and we have not yet been able to influence the onset of ageing. Unless we become able to do this, the population will ultimately fall by a quarter in each generation. In any case even if the population does not decline for some time the proportion of the young and of the producers will fall and that of the old and of the non-producers will rise. While in December, 1951 the population under 15 years was 22.1 per cent of the whole, it will be only 20.3 per cent in 40 years' time. During the same period, the proportion of women aged 15-44 to the whole population is expected to fall from 21.4 per cent to 19.8 per cent whilst the number of men aged 65 and over and women aged 60 and over will increase from 4.5 and 9.3 per cent respectively to 6.9 and 12.5 per cent respectively*. These figures make allowance for a continued improvement in mortality experience which is not in my opinion justifiable, on the current figures, and they are in my opinion over optimistic. In the financial year 1952-3 the Exchequer will pay £37,000,000 into the National Insurance Fund to enable income to cover expenditure. But by 1957-8 the sum will have risen to £150,000,000 and by 1977-78 the exchequer contribution will have grown to nearly £450,000,000.† This heavy liability in the years to come is due to the ageing of the population and the consequent increase in the expenditure on retirement pensions.

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* Registrar General's Provisional Vital Statistics for 1951.

† British Medical Journal, 1952, I, 207.

So although our economic difficulties are due to the fact that we have 20,000,000 people whom we cannot feed, the necessity for maintaining our population at its present level is paramount. A declining population is inevitably one in which the older people outnumber the younger, and in which the smaller proportion of active people must work increasingly harder to support the greater proportion of non-active. The only kind of population decline which is not accompanied by this state of affairs is one brought about by planned emigration of cross sections of all age groups of the community. It is interesting to note that the Commonwealth, above all Canada and Australia, cannot develop their resources for want of people.

We used to produce children to look after us in our old age. Now we expect the State to do it. But the State can only do it by allocating to the old by means of pensions a proportion of the production of the young. The amount available for distribution is dependent upon the number of producers and the real value of pensions cannot be maintained for more pensioners by fewer producers. We are badly in need of a real population policy in this country whereby people should be encouraged to have children. Nowadays children are a liability because they can no longer be exploited for financial gain by their parents at an early age. We want to assist people to have children by giving adequate family allowances, income tax reliefs, educational and housing provision, and so on, but as well as this we must alter the present attitude of the community to the parents of more than one or two children that there is something indecent or uncivilised in their action, let alone that it is downright stupid or must have been a mistake.

Death Rate:

The death rate for 1951 (8.1 per 1000) was 4.4 per 1000 below that for England and Wales (12.5 per 1000).

Infant Mortality Rate.

The infant mortality rate for 1951 (33.2 per 1000) was 3.6 per 1000 above that for England and Wales (29.6 per 1000). No significance should be attached to a rate of this size for a small authority.

Analysis of Mortality and Case Rates for certain Infectious Diseases.

No significance can be attached to the rates given for this Authority as the population is too small. It is hoped however that it will be of some interest to compare them with those for England and Wales. The one death from poliomyelitis which makes a rate of 0.06 was in a soldier stationed at Barton Stacey who died at Truro and whose death was for registration purposes transferred to this district. Probably the only other figures for which any explanation is required are the measles case rates for this Authority for this year and last, this year's being high and last year's low. This is due to the fact that although measles occurs more or less equally each year for the country as a whole it occurs in each area in alternate years, as it takes two years for the level of immunity in the community to fall as a result of new births to the point at which an epidemic can recur.

It is hoped that it will be noted that the mortality rate for England and Wales for poliomyelitits is nil and that the case rate for England and Wales for poliomyelitis is one third of that for food poisoning and erysipelas, one twentieth of that for pneumonia, one twenty second of that for scarlet fever, one seventy seventh of that for whooping cough, and one two hundred and eighty first of that for measles. Perhaps this may assist towards the preservation of a sense of proportion about the importance of poliomyelitis.

Year	Population.	%	E. & W.	Births	B. R.	E. & W.	Deaths	D. R.	E. & W.	I.M.	I.M.R.	E.&W.
1938	15160	100	100	215	14.2	15.1	114	7.5	11.6	10	46.5	53.0
1939	15400	101.6	100.6	236	15.3	15.0	111	7.2	12.1	7	29.7	50.0
1940	12300	81.1	96.8	216	17.6	15.2	174	14.1	14.4	8	37.0	56.0
1941	13150	86.7	94.0	237	18.0	14.2	166	12.6	12.9	15	63.3	59.0
1942	12050	79.5	92.8	254	21.1	15.8	130	10.8	11.6	10	39.4	49.0
1943	11470	75.7	91.8	223	19.4	16.5	119	10.4	12.1	9	40.4	49.0
1944	11070	73.0	91.7	234	21.1	19.9	128	11.6	12.7	11	47.0	45.0
1945	10820	71.4	92.0	210	19.4	16.1	126	11.6	11.4	7	33.3	46.0
1946	11490	75.8	98.5	234	20.4	20.2	129	11.2	12.0	7	29.9	43.0
1947	11680	77.0	101.4	299	25.6	20.5	132	11.3	12.0	3	10.0	41.0
1948	12510	82.5	103.7	287	22.9	17.9	110	8.8	10.8	7	24.4	34.0
1949	15020	99.1	104.6	308	20.5	16.7	128	8.5	11.7	8	26.0	32.0
1950	14900	98.3	106.3	311	20.9	15.8	116	7.8	11.6	5	16.1	29.8
1951	17590	116.0	106.3	301	17.1	15.5	142	8.1	12.5	10	33.2	29.6
Total				3565			1825			117		
Average					19.5	16.7		10.1	12.1		34.0	44.0

Population, 1951	17590
Population, 1938	15160
Total Increase	2430

Births, 1938–51	3565
Deaths, 1938–51	1825
Natural Increase	1740

Total Increase	2430
Natural Increase	1740
Immigration	690

VITAL STATISTICS 1938 – 51.

This year I also include a table giving Population, Population expressed as a percentage of the 1938 Population, Population of England and Wales expressed as a percentage of the 1938 Population, Births, Birth Rate, Birth Rate of England and Wales, Deaths, Death Rate, Death Rate of England and Wales, and Infant Mortality, Infant Mortality Rate, Infant Mortality Rate of England and Wales for each year from 1938, the last complete pre-war year, to 1951. It is hoped that this table showing the changes over a very eventful period will be of interest.

Population.

While the populations of England and Wales and of Andover Rural District declined steadily from 1939, the decline in the case of Andover Rural District was much steeper and lasted for a year longer (until 1945 instead of 1944). The subsequent increase was much larger in the case of Andover Rural District and lasted for a year longer (until 1951 instead of 1950). While the 1951 population of England and Wales was 6.3% above that for 1938, the 1951 population of Andover Rural District was 16.0% above that for 1938.

Births.

While the birth rate for England and Wales declined in the early years of the war and then increased until 1947, the birth rate for Andover Rural District increased throughout the period from 1938 to 1947. Since then both rates have declined. Andover Rural District's average birth rate over the period was 19.5, as against 16.7 for England and Wales and although Andover Rural District's was lower than that for England and Wales in 1938, it has been higher since 1939.

Deaths.

Apart from the big increase in 1940 the main feature is the low rate in Andover Rural District at the beginning and end of the period. Except in 1945 Andover Rural District's rate has been consistently below that for England and Wales and Andover Rural District's average of 10.1 compares favourably with that of 12.1 for England and Wales.

Infant Mortality.

These rates vary widely in the case of Andover Rural District as can be expected from a relatively small population and probably it would be necessary to take each year with that preceding and that following to get a reasonably smooth curve. Apart from 1941, 1944 and 1951, the rate for Andover Rural District has always been below that for England and Wales, but the gap is now narrowing because Andover Rural District's rate has always been much nearer what is in the present state of medical knowledge, the irreducible minimum. Andover Rural District's average of 34.0 compares favourably with that of 44.0 for England and Wales.

I have also included below the main table three small ones showing total increase in population over the period, natural increase (excess of births over deaths), and by calculation from the two former figures, immigration during the period. The population increased by 2,430, births exceeded deaths by 1,740, and immigration was 690. At four to a house it would require 173 houses to provide for these immigrants alone without providing for replacement of existing houses.

Live Births	Male	Female	Total
Legitimate	156 (146)	134 (149)	290 (295)
Illegitimate	8 (9)	3 (7)	11 (16)
Total	164 (155)	137 (156)	301 (311)

Still Births	Male	Female	Total
Legitimate	2 (3)	5 (0)	7 (3)
Illegitimate	0 (0)	0 (0)	0 (0)
Total	2 (3)	5 (0)	7 (3)

Deaths of Infants (under 1 year of age)	Male	Female	Total
Legitimate	9 (5)	1 (0)	10 (5)
Illegitimate	0 (0)	0 (0)	0 (0)
Total	9 (5)	1 (0)	10 (5)

Deaths of Infants (under 4 weeks of age)	Male	Female	Total
Legitimate	6 (3)	1 (0)	7 (3)
Illegitimate	0 (0)	0 (0)	0 (0)
Total	6 (3)	1 (0)	7 (3)

Deaths	Male	Female	Total
Tuberculosis, respiratory	1 (0)	1 (1)	2 (1)
Tuberculosis, other	1 (0)	0 (0)	1 (0)
Syphilitic disease	0 (1)	0 (0)	0 (1)
Diphtheria	0 (0)	0 (0)	0 (0)
Whooping cough	0 (0)	0 (0)	0 (0)
Meningococcal infections	0 (0)	0 (0)	0 (0)
Acute poliomyelitis	1 (0)	0 (0)	1 (0)
Measles	0 (0)	0 (0)	0 (0)
Other infective and parasitic diseases	1 (0)	0 (0)	1 (0)
Malignant neoplasm, stomach	2 (3)	3 (1)	5 (4)
Malignant neoplasm, lung, bronchus	5 (2)	1 (0)	6 (2)
Malignant neoplasm, breast	0 (0)	0 (1)	0 (1)
Malignant neoplasm, uterus	0 (0)	1 (0)	1 (0)

	Male	Female	Tctal
Other malignant and lymphatic neoplasms	7 (8)	3 (6)	10 (14)
Leukaemia, aleukaemia	3 (1)	1 (0)	4 (1)
Diabetes	1 (1)	1 (0)	2 (1)
Vascular lesions of nervous system	7 (7)	9 (9)	16 (16)
Coronary disease, angina	11 (5)	3 (3)	14 (8)
Hypertension with heart disease	0 (3)	3 (2)	3 (5)
Other heart disease	13 (12)	11 (16)	24 (28)
Other circulatory disease	0 (1)	0 (0)	0 (1)
Influenza	0 (0)	0 (0)	0 (0)
Pneumonia	4 (2)	4 (1)	8 (3)
Bronchitis	8 (3)	2 (1)	10 (4)
Other diseases of respiratory system	1 (0)	1 (0)	2 (0)
Ulcer of stomach and duodenum	0 (1)	0 (0)	0 (1)
Gastritis, enteritis and diarrhoea	0 (0)	1 (0)	1 (0)
Nephritis and nephrosis	2 (2)	0 (1)	2 (3)
Hyperplasia of prostate	0 (1)	0 (0)	0 (1)
Pregnancy, childbirth, abortion	0 (0)	0 (0)	0 (0)
Congenital malformations	0 (1)	1 (0)	1 (1)
Other defined and ill-defined diseases	13 (7)	7 (7)	20 (14)
Motor vehicle accidents	4 (5)	0 (0)	4 (5)
All other accidents	1 (0)	2 (0)	3 (0)
Suicide	0 (0)	1 (1)	1 (1)
Homicide and operations of war	0 (0)	0 (0)	0 (0)
All causes	86 (66)	56 (50)	142 (116)

THE CHEMICAL MANIPULATION OF FOOD

The insertion of some information on this subject immediately following the " Deaths " table is intentional. It is my opinion that the increase in the diseases of civilisation or degenerative diseases, such as cancer, cerebral haemorrhage, coronary thrombosis and angina pectoris and peptic ulcer is caused by the unnatural nature of our diet. Diseases other than the degenerative diseases are decreasing, and surely faulty nutrition is the most likely explanation of the increase in the latter. The incidence of these diseases is much greater in Western countries, and the obvious explanation is that this is due to modern errors of living, of which the ingestion of chemically treated food is the most obvious. Chemicals may not only confer toxic properties on food, they may by their action remove or destroy important constituents or dilute the nutritional constituents with air or water.

Of the four sweetening agents that have been in use, two including saccharin have not been found to cause any damage, but of the other two one caused liver tumours and the other kidney damage. The most commonly used colouring substances in food belong to the azo-dye group. In the United States and Canada only those azo-dyes may be used which are specified as harmless, but in this country all those azo-dyes may be used which are not specified as harmful. Among those which have been found to be harmful, a large number cause malignant tumours of the liver, including one with the euphemistic title of butter-yellow, and these azo-dyes are all of the same group as those others for used colouring food.

White flour is so widely used as an article of diet that the substances used in the treatment of flour are of particular interest. The best known is nitrogen trichloride which is a bleacher and (another euphemism) improver, that is to say it makes the loaf lighter by allowing more air and gas to be incorporated so that a slice of given volume contains less nutriment. Agene (as nitrogen trichloride is popularly known) has been proved to cause hysteria in dogs, and in fact no species of animal tested with the substance produced by nitrogen trichloride by action on the flour has failed to show toxic symptoms of the central nervous system. There is certainly a big enough increase in nervous disease to justify consideration of this matter, but although the United States have given up nitrogen trichlorine it is still used in this country. It is also worth mentioning that the toxic substance which nitrogen trichloride produces by action on the flour is formed by the destruction of a valuable constituent of the flour, so that the customer has a food replaced by a possible poison. There is no certainty that any other bleacher or improver which may be used may not ultimately be found to have the same two effects.

Another group of widely used chemicals in food are the emulsifiers, which make flour confectionery more tender. Certain of these if impure are actually poisons, and this emphasises the importance of purity of these products. But there is evidence that even in the pure state certain emulsifiers cause gastro-intestinal disturbances. There is no lack of gastro-intestinal complaints in this country today, but although the number of emulsifiers which may be used in food has been very strictly reduced in the United States, nothing has been done here.

Even where chemicals do not actually cause harm they may reduce the nutritive value of food, by taking the place of other ingredients which are of food value. We can no longer rely on our senses to tell us whether food is what it should be. The fat-sparers come in this category, as their name implies, and they are widely used. The flour " improvers " have already been mentioned.

The last category I would like to include are the pesticides, chemicals used in agriculture. Many of these in large doses are very toxic, and while the concentration used in spraying may not be high, they are absorbed into the plant. These chemicals in high concentration cause cancer of the liver in animals, and the significant feature is that they are absorbed and stored by the body over long periods with a cumulative effect. Many people engaged in the preparation and use of these substances have been killed or injured by them, but much the more important question is, what happens to the consumer?

In this country the Ministries responsible for our food are those of Food and of Agriculture and Fisheries. Now the objectives of these two Ministries must be to produce as much food as possible and food which the consumer finds acceptable, and these objectives must conflict with that of the effect of food on health. It would be much better if the responsibility for all questions involving the addition of unnatural chemicals to food rested with the Ministry of Health.

At several points I have shown that practice in the United States is much ahead of that in this country. There is in the United States a large and important department called the Food and Drugs Administration, which is reponsible for this question of the addition of chemicals to food and this provides the explanation for progress there. In this country the only organisation is the toxicological research unit of the Medical Research Council but its objectives are quite different and much more limited. The position is that we are in the undignified position of having to rely on the decisions arrived at in the United States before policy or action can be determined here. It is not as if the questions at issue were small and of rare occurrence. Questions of great public interest are constantly coming up, and the Food and Drugs Administration is very active. The establishment of a similar department in this country is long overdue.

For much of the information given above I am dependent on an article by Sir Edward Mellanby in the British Medical Journal 1951, II, 863, but it ties up with what I said on the subject of food in my last annual report. What is most important in food is that it should be fresh, natural and wholesome, not processed, sophisticated, and adulterated. Foot and mouth disease is much in the news just now, and I repeat again that Sir Albert Howard found that cattle fed on pasture fertilised by returning to it the whole of the animal and vegetable refuse of the community could actually rub noses across a fence with cattle suffering from foot and mouth disease without contracting the infection. Mr. Friend Sykes who farms some seven miles from Andover has eradicated contagious abortion by similar means and at a meeting which I suggested of the Southern Branch of the Society of Medical Officers of Health he spoke of this and other achievements with animals and with crops. Sir Robert McCarrison found that whereas rats fed on natural food grew well, had little disease and lived happily together, those fed on processed food grew ill, had much disease and lived unhappily together, the strong killing and eating the weak. There, if anywhere is a parable for the times in which we live.

If it was even accepted as a principle that where possible fresh natural and wholesome food should be the objective, much would be gained. A moment's thought shows that this objective is very far from being considered today. The latest proposal is to add fluorine to water, as fluorine has a proved effect in postponing the onset of dental decay, although it is not proved that it prevents it. But there is ample fluorine for this purpose in the wheat berry which we throw away when we make white flour. Maybe water should have fluorine added, but I would like first to see a study of the comparative mortality figures for the degenerative diseases in those areas which already have naturally a high fluorine content in their water.

SMOKING AND CANCER OF THE LUNG

Last year I included a note on a recent statistical investigation of the relationship between smoking and cancer of the lung, and as it is an obvious example of preventive medicine, I include it again with additions*. Whereas among a control group of men and women without cancer of the lung 4.2% of the men and 53.3% of the women were non-smokers, among a group of 649 men and 60 women with cancer of the lung only 0.3% of the men and 31.7% of the women were non-smokers. Whereas among the control group 13.5% of the men and 0% of the women smoked 25 or more cigarettes a day, among the group with cancer of the lung 26% of the men and 14.6% of the women smoked 25 or more cigarettes a day. It was calculated that above the age of 45 the risk of cancer of the lung was 50 times as great among those who smoked 25 or more cigarettes a day as among non-smokers. During the 25 years between 1922 and 1947 the annual number of deaths recorded in England and Wales increased from 612 to 9,287. During the 9 years between 1940 and 1949 the annual number of deaths recorded in England and Wales increased from 5,227 to 11,182.† Between 1949 and 1950 the death rate for cancer of the lung for men for England and Wales rose from 484 to 530 per million population‡. Cancer takes 10-15 years to develop, and the spectacular increase in smoking has been since 1939. What its results will be remain to be seen. What is the responsible factor in cigarettes is not known but the obvious advice to anyone contemplating taking up smoking is " Don't."

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* British Medical Journal, 1950, II, 739.
† British Medical Journal, 1951, II, 235.
‡ Medical Officer, 1952, I, 202.

SECTION B.

GENERAL PROVISION of HEALTH SERVICES FOR THE AREA.

National Health Service Act, 1946

Local Health Services under Part III.

In paragraph 20 of Ministry of Health circular 112/47 it was recommended that all counties should be subdivided according to local health requirements, that in each subdivision the County Health Committee would use its powers (under paragraphs 6 and 7 of Part II of the Fourth Schedule to the Act) to appoint a Sub-Committee on which the Councils of County Districts comprising the subdivision would be represented, and to which would be delegated the day-to-day administration in the division of the Part III (Local Health Authority) Services of the National Health Service Act, and that, under the County Medical Officer, executive charge of these services in the division would be taken either by an existing Assistant County Medical Officer, preferably one who was also Medical Officer of Health of one or more of the districts constituting the Division, or by the Medical Officer of Health of one of these districts, who would be appointed to the staff of the County Medical Officer. The County Council as the Local Health Authority would of course retain its responsibility for policy and finance unimpaired but to day-to-day adm inistration the Sub-Committee would bring the local interest and knowledge which are so desirable in such personal services.

In paragraph 7 of Ministry of Health circular 27/51 county councils were again recommended to have regard to the advantages which might be expected to flow from a plan, which besides providing for a single officer to hold the office of medical officer of health for two or more county districts where this was appropriate, also provided for him to be employed part-time in county council services and so to help to administer the personal health services of the county council in the area in addition to discharging the duties which fell to him as county district medical officer of health. The Minister was sure that such arrangements were in the interests of the local services, as well as of the officers themselves, because they secured to those services the help of medical officers experienced in the administration of both kinds of local health services environmental and personal. The marked growth in recent years of arrangements of this kind was itself sufficient testimony of their value and practicability.

The recommendations of the Delegation Sub-Committee of the Local Government Manpower Committee which were published by the Committee and which were endorsed by the then Minister of Local Government and Planning, included recommendations similar to those of Ministry of Health Circular 118/47.

A memorandum agreed by the Council of the Society of Medical Officers of Health, which was published by the Society, stated that the Society of Medical Officers of Health was in favour of decentralisation of National Health Service Part III functions by county councils wherever practicable, that the Society considered that such decentralisation should be to sub-committees of county health committees (as authorised by the Fourth Schedule Part II, paragraphs 6 and 7) which should be responsible for day-to-day administration of some or all of the Part III Services, that the medical officer appointed to serve the sub-committee normally had other duties to perform and might be medical officer of health of one or more of the county districts in the area, that so far as the medical officer's duties under Part III of the National Health Service were concerned he acted as a senior member of the staff of the county medical officer, and that policy, finance, and establishment were retained as functions of the central committee.

Even up to 1949 (no more recent figures are available) 31 of the 62 Counties in England and Wales had carried out the recommendations of the Minister of Health contained in paragraph 20 of circular 118/47, but no such subdivision has taken place in Hampshire. Charge of duties under Section 26 (Vaccination and Immunisation) is taken by the medical officer of health, but charge of duties under Sections 22 (Care of Mothers and Young Children), 23 (Midwives), 24 (Health Visitors), 25 (Home Nursing), 27 (Ambulance), 28 (Prevention of Illness, Care, and After-Care) and 29 (Domestic Help) remains with the County Medical Officer. The District Health Sub-Committee has advisory functions only in connection with Sections 23 (Midwives), 25 (Home Nursing) and 29 (Domestic Help) only, but the officers carrying out these services come directly under the control of the County Health Committee and are in no way answerable to the District Health Sub-Committee.

SECTION 26

(VACCINATION AND IMMUNISATION)

This is therefore the only one of the Part III (Local Health Authority) Services under the National Health Service Act on which I am able to report.

Notification of birth cards received by the County Medical Officer from the Health Visitors are sent to the Medical Officer of Health, who prepares Diphtheria Immunisation Record Cards from them, and these form a Diphtheria Immunisation Card Index. Consent cards received by parents from the Health

Visitors are sent to the Medical Officer of Health who sends the corresponding Diphtheria Immunisation Record Cards to the general practitioners and they perform the immunisation. A Diphtheria Immunisation Clinic is also conducted by the Medical Officer of Health with the assistance of the Health Visitors at the Health Centre, Junction Road, Andover, at 11 a.m. on the first Saturday in the month for those children whose parents wish them to be immunised by him.

DIPHTHERIA IMMUNISATION

Annual Return for year ended 31st December, 1951

Number of children who completed a full course of Primary Immunisation in the Authority's area (including temporary residents) in the above year.			Total number of children who were given a secondary or reinforcing injection (i.e. subsequent to complete full course).
Age at date fo final injection		Total	During year ended 31st December, 1951
Under 5	5 to 14		
262	0	262	279

The figures of 279 for total number of children who were given a secondary or reinforcing injection (i.e. subsequent to complete full course) compare with 5 for the previous year and are the result of a campaign to improve the state of immunity of the school children.

A letter was prepared by the Medical Officer of Health giving details of the advisability of primary and reinforcing immunisation and requesting return of an attached consent form giving details of who it was desired should carry out the immunisation and of the child's immunisation state. Copies of this letter were sent to the Head Teachers of all Primary Schools for distribution to all children (not to those aged 5 and 10 only who are normally the only ones who receive reinforcing immunisation, as many children aged 6 to 9 had escaped reinforcing immunisation in recent years). Consent forms completed by the parents were returned by the Head Teachers to the Medical Officer of Health and were examined to see whether the child required reinforcing immunisation. Where the parent had requested that the Medical Officer of Health should carry out the immunisation, Diphtheria Immunisation Reinforcing Injections Record Sheets were prepared and sent to the general practitioners who were asked to carry out the immunisations at the schools on behalf of the Medical Officer of Health, with payment on a sessional basis, the schools being allocated among them proportionately and with regard to the area of their practice. Where the parent had requested that the general practitioner should carry out the immunisation, Diphtheria Immunisation Record Cards or Diphtheria Immunisation Reinforcing Injections Record Sheets were prepared and sent to the general practitioners, with payment on a per capita or sessional basis respectively, depending on the number to be immunised. Arrangements for all sessions were made by the Medical Officer of Health. Unfortunately some of the general practitioners were unable to carry out the immunisations before the end of the year and it is feared that the Diphtheria Immunisation Reinforcing Injections Record Sheets may have become out of date due to children moving on to the secondary schools or leaving the district, and that children who should have been immunised may have been missed. However this has worked fairly well and there has been a considerable increase in the proportion of children who have received a reinforcing injection. It is considered that in future years it will be necessary to send the letter to the parents of children aged 5 and 10 only.

Immunisation in Relation to Child Population

Number of children at 31st December, 1951 who had completed a course of immunisation at any time before that date. (i.e. at any time since 1st January, 1937).

Age at 31st Dec., 51 Under :	1	1	2	3	4	5 to 9	10 to 14	Total
i.e. Born in year :	1951	1950	1949	1948	1947	1942–46	1937–41	Under 15
Number immunised :	18	290	208	260	257	275	12	1320

Estimated mid-year child population	Children under 5	Children 5 to 14	
1951	1540	2377	3917

Diphtheria Notifications and Deaths in Relation to Immunisation during the year 1951

NIL.

The 1033 immunisations performed on the 1540 children under 5 represent a percentage of 67.1, the 287 immunisations performed on the 2377 children from 5-15 represent a percentage of 12.1, and the 1320 immunisations performed on the 3917 children under 15 represent a percentage of 33.7.

These percentages for 1951 may be compared with 70.1%, 6.4% and 32.1% for 1950, and show an improvement. They may also be compared with 61.6%, 69.0%, and 66.3% for rural districts, and with 57.0%, 68.3% and 63.9% for the County for 1950. It will be seen therefore that our percentages for under 5's are

5.5% above those for rural districts, and 10.1% above those for the County, for the previous year, but our percentages for 5's–15's are 56.9% below those for rural districts and 56.2% below those for the County for the previous year, and our percentages for all children are 32.6% below those for rural districts and 30.2% below those for the County, for the previous year. These figures represent the result of a complete search through all our records, and indicate that these records are obviously very far from complete.

The cause of this apparently unsatisfactory state of affairs is the return itself. It will be seen that it demands figures dating back to 1937, that is 15 years old. But what is even more unfortunate is that the return was only introduced in 1945, in which year it demanded figures dating back to 1931, that is 15 years old at that time. It is most unlikely that all the figures submitted at that time were based on records, and many of them must have been estimates. Because of the peculiar nature of the return, later figures based on records have been added each year to those earlier figures, conferring on them an appearance of accuracy to which they may not have been entitled. The accuracy of this return in every case will not really be certain until 15 years from the date of its introduction and comparisons based on returns at the present time are not necessarily of any great value. It will be seen also that figures for immunised children between the ages of 5 and 14 are given in two 5 year age groups which in each year's return refer to two groups of 5 calendar years a year later than the two groups of the previous year's return, so that the return cannot be based on that for the previous year, but only on the records on which that return was based. In the case of this Authority, the only records which I was able to find give the figures which I have set out above. Because of the nature of the return, it is not unlikely that many authorities submit returns based on estimates.

THE DECLINE IN DIPHTHERIA IMMUNISATION

The drop of nearly 27,000 in immunisations done in the first months of 1950 as compared with the same period in 1949 was followed by a drop of over 140,000 in immunisations done in the 0-5 age group, in the whole year as compared with 1949, 433,000 as compared with 574,000. Fortunately there was a large recovery to 497,000 in 1951, but this is still well short of the 1949 figure and it is the overall level of immunity in the population that is important in preventing the spread of the disease, so that it is most important to recover the ground lost. Fear of diphtheria is declining, and the very success of the immunisation campaign in almost eliminating diphtheria has led to some apathy on the part of mothers who do not realise that this is conditional upon the maintenance of an adequate level of immunisation. In

1951 deaths numbered 34 against a yearly average of about 2,800 between 1930 and 1940, and notifications (uncorrected) were 1,983 and (corrected) 699 compared with a yearly average of 55,000 in the same decade. The fall in the numbers of cases and deaths is due to the immunisation campaign. Over the three-year period 1945-47 the notification rate among children under 15 in England and Wales was three times higher, the death rate was 22 times higher, and the fatality rate (deaths per cent of notifications) was 7 times higher, among the non-immunised than among the immunised children*. The condition is not becoming less serious. Over the eight year period 1944-51 the fatality rate (deaths per cent of notifications) has actually tended to increase†.

It is very important therefore to find the cause for the decline. Last year I suggested that it was due to the scare which developed following the reports which appeared in the medical press during the early months of 1950 which showed that there was a rare but statistically significant relationship between diphtheria immunisation and poliomyelitis in the inoculated limb, and that it would have been well if before these reports appeared their authors had considered whether the harm to the community as a result of the decrease in the number of immunisations did not outweigh the advantage as a result of the reduction in the number of cases of poliomyelitis.

I still think that these reports were the main cause of the decline, although I have no doubt that the success of the immunisations has resulted in decline of the fear of the disease and in fact in reduction of the number of people who have any experience or even knowledge of the disease. A recent report† however tends to lead one to the conclusion that the scare was more among the authorities than the parents, although its authors do not themselves make the calculation from their own figures that justified such a conclusion. In this report it is stated that whereas the proportion immunised at the clinic fell from 62% in 1949 to 49% in 1950, that immunised by the family doctor increased from 35% in 1949 to 47% in 1950, and that immunised at other places increased from 3% in 1949 to 4% in 1950, but this matter is not discussed further, and it is presumed that the family doctor is taking over immunisation from the clinic.

However, if we apply these percentages to the figures for immunisation in 1949 and 1950 (574,000 and 433,000) we find that whereas the number immunised at the clinic fell from 355,880 in 1949 to 212,170 in 1950, or to three-fifths, the number immunised by the family doctor remained more or less stationary (203,510 in 1950 as against 200,900 in 1949) and the number immunised at other places remained more or less stationary (17,320 in 1950 as against 17,220 in 1949). No doubt the percentages themselves which were obtained from a sample do not really justify so accurate an estimate of the figures for the country as a whole but the figures are so striking that they are obviously of importance.

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* Monthly Bulletin, Ministry of Health and Public Health Laboratory Service, 1952, 51.

† Monthly Bulletin, Ministry of Health and Public Health Laboratory Service, 1952, 27.

What has happened is that the family doctor has rightly concluded that the importance of poliomyelitis in relation to diphtheria immunisation is exaggerated and has continued his activities unchecked, while the clinic has reduced its activities to little more than half. Whether this is mainly the responsibility of the central authority or of the local authority, it is impossible to say. Certainly the complete cessation of publicity measures by the central authority in the summer and autumn of 1950 must have been a very important factor. No doubt individual local authorities assessed the matter at its true value while others grossly exaggerated the dangers. I can only repeat what I said last year, that what is wanted is a statistical investigation to show whether the possiblity of death or disablement through poliomyelitis in the immunised is greater than the possibility of death or disablement through diphtheria in the unimmunised, and that there can be very little doubt that it would be shown that our timidity has been entirely unjustified.

SECTION F

Prevalence of, and Control over, Infectious and other Diseases.

Final numbers according to Sex and Age after Corrections of Cases of Infectious and other notifiable Diseases notified during the year ended 31st December, 1951.

	Scarlet fever			*Whooping cough*			*Measles*		
	M	F	Tot.	M	F	Tot.	M	F	Tot.
Under 1 year					1	1	3	7	10
1– 2 years	1		1	4	3	7	26	25	51
3– 4 ,,	4	2	6	4	6	10	33	36	69
5– 9 ,,	2	6	8	9	7	16	87	72	159
10–14 ,,		1	1	1		1	5	10	15
15–24 ,,				1		1	4	1	5
25 and over								4	4
Age unknown									
Total : (All ages)	7	9	16	19	17	36	158	155	313

	Acute Pneumonia		
	M	F	Total
Under 5 years	1		1
5–14 years			
15–44 ,,			
45–64 ,,			
65 and over			
Age unknown			
Total : (All ages)	1		1

Puerperal pyrexia	*Ophthalmia neonatorum*			*Malaria*		
Female	Male	Female	Total	Male	Female	Total
1	1		1	1		1

INFECTIOUS DISEASES

As already mentioned, the large number of cases of measles for this Authority is due to the fact that although measles occurs more or less equally each year for the country as a whole, it occurs in each area in alternate years, as it takes two years for the level of immunity in the community to fall, as a result of new births, to the point at which an epidemic can recur. The case of opthalmia neonatorum was non-venereal and the condition cleared up satisfactorily. The case of malaria was of the benign tertian variety and was in a soldier who had contracted it abroad.

I would like to repeat again what I said about whooping cough last year. It is by far the most serious of the common infections of childhood at the present time. All infections follow waves of virulence and the virulence of scarlet fever is at present no more than that of measles, or possibly even less. Whooping cough therefore stands out above all others and it is good news that a recent statistical investigation* has disclosed that immunisation against whooping cough is of real value. Over a two to three year period of observation 149 of the 3801 vaccinated children developed whooping cough, whereas 687 of the 3757 unvaccinated children developed whooping cough, giving attack rates per 1000 child months of 1.45 and 6.72 respectively, and a reduction in the incidence of the disease of 78%. Among children exposed to whooping cough in their own homes the attack rates were 18.2% in the vaccinated and 87.3% in the unvaccinated groups. The cases that occurred in the vaccinated were on the average less severe and of shorter duration than those in the unvaccinated children. Five vaccines were tested, of which much the most effective were two prepared by the Michigan Department of Health, but the other three were also of value. The further comparative investigations which I mentioned in my last report are not yet complete, but it is hoped that it will soon be possible to undertake a campaign similar to that already undertaken for diphtheria immunisation, and that the Public Health service will be able to take the same part in the second campaign as it has done in the first.

TUBERCULOSIS

	New Cases						**Deaths**					
Age Periods	Respiratory			Non Respiratory			Respiratory			Non Respiratory		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
0—												
1—												
5—		1	1									
15—	4	2	6									
25—	3	1	4		1	1						
35—	1	1	2				1		1			
45—	2	1	3									
55—												
65 and upwards												
TOTAL	10	6	16		1	1	1		1			

Number of cases on the Tuberculosis Register on 31st December, 1951 :

(31st December, 1950 in brackets)

	Male		Female		TOTAL	
Respiratory	24	(20)	16	(12)	40	(32)
Non Respiratory	3	(3)	3	(2)	6	(5)
TOTAL	27	(23)	19	(14)	46	(37)

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* British Medical Journal, 1951, I, 1463.

TUBERCULOSIS

During the year a complete investigation has been made into all the cases on the Tuberculosis Register and on the list kept by the Chest Physician and a complete new Register has been prepared. As a result the figures shown for last year do not agree with those given in last year's Annual Report but it is hoped that the picture now presented is an accurate one. As I stated last year the Tuberculosis Register is the most difficult to maintain accurate of the records which have to be kept by the Medical Officer of Health. The increase in the number of cases which is shown on the Return is due to the addition of cases which were on the list kept by the Chest Physician but not on the Register. Incidentally 24 cases were removed from the Register as a result of the investigation, although it was not possible to show these on the Return as having existed at the beginning of the year. These were removed from the Register as follows :— Recovered, 7; Dead, 0; Left District, 15; Not found in District after adequate search, 2—Total 24.

It remains only to repeat again the plea I made last year for the wider use of B.C.G. (Bacille Calmette Guerin) vaccination against tuberculosis, and to quote from some references to this subject which I have noted during the year.

The most interesting was an article on " Tuberculosis in Families with B.C.G. vaccinated and non-vaccinated children."* In this article an approach was made to the problem by examining those families in whom some children had been vaccinated and others not. A search was made in the records of the Nortull's Hospital, the Samariten Hospital, and the Central Tuberculosis Dispensary, Stockholm. In general all families with B.C.G. vaccinated and non-vaccinated children exposed to a known source of infection, and irrespective of whether or not there was any case of tuberculosis among the children, were included. In all there were 16 families, with 22 vaccinated and 22 non-vaccinated children. Among the 22 children in the non-vaccinated group 21 developed primary tuberculosis. In the B.C.G. vaccinated group two at most showed some evidence of superinfection.

In the same article the difference in the incidence of tuberculosis in the vaccinated and non-vaccinated children admitted to Nortull's Hospital was recorded. Of the cases of primary tuberculosis 26 of the 1352 vaccinated children had developed tuberculosis (1.9%). 12 of these cases were mild and 14 more or less typical, but some of the latter had been vaccinated so long before that it is very likely the immunity had disappeared.

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* British Medical Journal, 1952, I, 682.

During this 5 year period 8.2% of the non-vaccinated children who had been admitted to the hospital had developed the disease. There were 28 cases of tuberculous meningitis and/or miliary tuberculosis in the non-vaccinated group and none in the vaccinated group. The number of cases of primary tuberculosis had fallen from 183 admissions in 1945 to 88 in 1949, with an average of 123 in the intervening years.

At a Conference on Infectious Diseases held in Copenhagen during the week 2nd–6th July, 1951, Dr. Winge, Dr. Torning, and Dr. Jensen all referred to the benefits arising from the use of B.C.G. vaccination in Denmark*. Since 1936 no case of tuberculous meningitis had been observed in a person successfully converted by B.C.G. vaccination, and Professor Lassen, reporting that for many years in Blegdams Hospital beds had been set aside for cases of primary tuberculosis, stated that in 1949 there were 72 such beds, in 1950, 54; and in 1951, 18; and that at that time only 10 of these beds were occupied.

In an article on Tuberculosis Control in Denmark† it was stated that the death rate from all forms of tuberculosis in Denmark in 1950 was provisionally announced as 14 per 100,000, i.e. less than half of the figure for England and Wales and the lowest ever recorded in any country. Since 1938 deaths from pulmonary tuberculosis had decreased by about 50 per cent but those from tuberculous meningitis by over 80 per cent. No case of tuberculous meningitis, miliary tuberculosis, or progressive pulmonary tuberculosis had been observed among the children known to the Copenhagen tuberculosis clinic and vaccinated with B.C.G., though some lived in contact with open pulmonary cases.

In this country an appeal was made by the Portsmouth health department that B.C.G. vaccine should be given to all tuberculin negative school-leavers‡. Authority was requested for the Mass Radiography Unit, which already had the cooperation required with this group of the population, to commence this work, but permission was refused. Here, in spite of 20 years Scandinavian experience we continue to experiment with the administration of B.C.G. vaccine to medical students, nurses, and tuberculin-negative contacts of cases of tuberculosis only. What is wanted in this case also is a campaign similar to that already undertaken for diphtheria immunisation and again it is hoped that the Public Health Service will be able to take the same part in this campaign as it has done in that for diphtheria immunisation.

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* British Medical Journal, 1951, II, 354.

† Bulletin of the National Association for the Prevention of Tuberculosis, 1951, 609.

‡ Medical Officer, 1951, II, 175.

NATIONAL ASSISTANCE ACT 1948

Section 47. Removal to suitable premises of persons in need of care and attention.

No action has been taken by the Council under this Section.

FOOD POISONING OUTBREAKS

No outbreaks of food poisoning occurred during 1951.

CLEAN FOOD CAMPAIGNS

A Clean Food Exhibition was held in the Guildhall, Andover, from Wednesday to Saturday 17th to 20th October, 1951, from 2 to 7 daily. Exhibits were provided by the Ministry of Health, the Ministry of Food, the Central Council for Health Education, and Marks and Spencer. The Public Health Laboratory Service provided a viewing box with culture plates, and charts, pictorial diagrams, and photographs on the bacteriology of food poisoning. The County Education Committee provided a most attractive display of a day's meals for a family including an actual school meal and a demonstration of home food storage for the family of limited means. The Southern Gas Board provided single point and multi point storage water heaters, a non-storage single point water heater, a boiling water heater, a circulator (substitute for boiler in ordinary circulation), an incinerator (for sanitary towels) and a sterilizing sink. The Southern Electricity Board provided a refrigerated display counter, a refrigerator, a beer glass washer, a vacuum cleaner, an air extractor, a food mixer, and a storage water heater. Shows of the films "Another Case of Poisoning," " Fly About the House," and " Common Concern," were given at 6.15 daily and at 3.30 on Saturday. Cookery demonstrations were given on Wednesday and Friday at 3.30 by the Southern Gas Board.

The Exhibition was extremely attractive and compared not unfavourably with professional exhibitions. The attendance was not as large as had been hoped, in spite of newspaper, cinema, poster, and radio publicity, but no smaller than had been expected.

Film Shows and Discussions on Health Education including Clean Food were offered during the year to a number of existing organisations and given to those that accepted the offer.

SECTION C

1. WATER SUPPLY

There have been no extensions of water mains during the year from sources within the area.

Work was commenced on laying of mains from the Winchester R.D.C's. supply at Sutton Scotney for a bulk supply to the villages of Bullington and Barton Stacey.

Chlorination of the supply to Faberstown and Appleshaw, and of the bulk supply afforded to Pewsey R.D.C. for Ludgershall, was continued.

Regular sampling of the Vernham Dean source showed evidence of very slight intermittent pollution and chlorination of the supply was therefore instigated.

39 samples of pre-chlorinated water were taken for bacteriological examination from the Faberstown source, of which 23 were reported as satisfactory and 16 as not entirely satisfactory.

At Vernham Dean 32 samples of pre-chlorinated water were taken, of which 12 proved to be slightly contaminated.

The reasons for the slight intermittent contamination of either the Vernham Dean or Faberstown sources could not be ascertained, but the possibility of contamination by household drainage through fissures in the chalk cannot be over-ruled.

In areas served by piped supplies, particulars of populations supplied are as follows :—

	No. of Dwellings supplied from mains.	No. of Population supplied by Stand-pipe.
Appleshaw part Fyfield, Kimpton	170	64
Vernham Dean	83	25
Shipton Bellinger (Cholderton Water Co.)	193	—

South Tedworth a War Department establishment has its own supply.

In view of the very small portion of the area which is now served by a piped supply, the provision of a comprehensive scheme for a piped water supply to the whole area is an urgent matter.

Bacteriological Examination of Water Supplies:

Number of samples taken	327
,, ,, ,, reported satisfactory	246
,, ,, ,, ,, not entirely satisfactory ..	47
,, ,, ,, ,, unsatisfactory	34

2. DRAINAGE and SEWERAGE

Faberstown.

The construction of sewers at Faberstown to link up with the sewerage system of Ludgershall (Pewsey R.D.C.) was completed towards the end of the year. It is hoped to secure the connection of all houses in Faberstown to this system.

3. PUBLIC CLEANSING

The weekly collection of refuse from all the houses in the district with the exception of a few remote premises, was satisfactorily continued during the year. Since the weekly collection started, parishioners have become more conscious of the need to remove refuse from their premises instead of accumulating it as they have done over many years in the past. There are still large ash and refuse heaps to be seen in cottage gardens.

Emptying of cesspools and buckets is undertaken by the Hampshire Cleansing Service, on behalf of the District Council in the Parish of Shipton Bellinger.

4. SANITARY INSPECTION OF THE AREA

Inspection for Nuisances	23
Drainage Tests	45
Rooms Disinfected	3
Inspection of Water Supplies	401
Dairy Inspections	3
Inspection of Movable Dwellings	37

5. SHOPS

No statutory action was taken during the year.

6. CAMPING SITES

There are no licensed camping sites in the district. Licences under the Public Health Act, 1936, have been issued to twenty eight persons to station and use movable dwellings.

7. ERADICATION OF BED BUGS

No cases of bed bug infestation came to the Council's notice.

8. FACTORIES

Inspections for purpose or provisions as to health (including inspections made by the Sanitary Inspector).

Premises	Number on Register	Number of Inspections	Number of Written Notices
(i) Factories in which Sections 1,2, 3, 4, or 6 are to be enforced by Local Authority	6	3	—
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	22	15	—
(iii) Other Premises in which Section 7 is enforced by the Local Authority (excluding out-workers' premises)	—	—	—
TOTAL	28	18	—

Cases in which DEFECTS were found :

Particulars	No. of cases in which defects were found			
	Found	Remedied	Referred To H.M. Inspector	Referred By H.M. Inspector
Want of Cleanliness (S.1)	1	1	—	—
Overcrowding (S.2)	—	—	—	—
Unreasonable temperature (S3)	—	—	—	—
Inadequate ventilation (S.4)	—	—	—	—
Ineffective drainage of floors (S.6)	—	—	—	—
Sanitary Conveniences (S.7)				
(a) Insufficient	—	—	—	—
(b) Unsuitable or defective	—	—	—	—
(c) Not separate for sexes	—	1	—	—
(d) Other offences	—	—	—	—
TOTAL	1	2	—	—

9. SCHOOLS

Some improvements such as the installation of washbasins have been carried out at Council or Controlled Schools since my special report on schools in 1950.

SECTION D

HOUSING INSPECTIONS

1. (a) Total number of dwelling houses inspected for housing defects (Public Health and Housing Acts.) .. 69

   (b) Number of inspections made for the purpose .. 145

2. (a) Number of dwelling houses (included under (1)) which were inspected and recorded under Housing Consolidated Regulations 1925 and 1932 34

   (b) Number of inspections made for the purpose .. 34

3. Number of dwelling houses found to be in a state so dangerous or injurious to health as to be unfit for human habitation 5

4. Number of dwelling houses (exclusive of those referred to under the preceding sub-head) found not to be in all respects reasonably fit for human habitation 29

Housing Action

Remedy of Defects during the year without service of formal notices :—

Number of defective dwelling houses rendered fit in consequence of informal action by the Local Authority or their officers 12

Action Under Statutory Powers during the Year

(a) Proceedings under Sections 9, 10 and 16, Housing Act, 1936

(1) Number of dwelling houses in respect of which notices were served requiring repairs .. .. .. Nil

(2) Number of dwelling houses which were rendered fit after service of formal notice—

(i) By owners .. .. Nil

(ii) By Local Authority in default of owners .. .. Nil

(b) Proceedings under Sections 11 and 13 Housing Act, 1936.

(1) Number of dwelling houses in respect of which Demolition Orders were made .. .. .. Nil

(2) Number of dwelling houses demolished in pursuance of Demolition Orders .. .. Nil

(c) Proceedings under Section 12 of Housing Act, 1936.

(1)	Number of separate tenements or underground rooms in respect of which Closing Orders were made	Nil
(2)	Number of separate tenements or underground rooms in respect of which Closing Orders were determined, the tenement or room having been rendered fit	Nil

Housing Act, 1936.—Part IV.—Overcrowding

(a)	(i)	Number of dwellings overcrowded at end of year Estimated	30
	(ii)	Number of families dwelling therein—Estimated	50
	(iii)	Number of persons dwelling therein—Estimated	150
(b)		Number of new cases of overcrowding reported during the year	2
(c)	(i)	Number of cases of overcrowding relieved during the year	6
	(ii)	Number of persons concerned in such cases	35
(d)		Particulars with respect to overcrowding conditions upon which the Medical Officer of Health may consider it desirable to report. No special circumstances.	

SECTION E

INSPECTION AND SUPERVISION OF FOOD

(a) Milk Supply

Number of Registered Distributors	1
Number of Registered Distributors outside area selling milk within the area	7

Practically all the milk consumed in the district is supplied by the large retail dairymen with pasteurising plant, whose dairies are situated in the Borough of Andover or in Wiltshire County districts.

(b) Slaughterhouses

There are two licensed slaughterhouses but no slaughtering other than pig killing for private individuals is carried on. There are four butchers shops including the NAAFI shop at South Tedworth, all of which are maintained in a clean condition.

(c) Ice Cream

There are thirty two registered retailers of ice cream. All these retailers except two sell prepacked ice cream. The only manufacturer in the district ceased manufacturing when recording thermometers for heat treatment processes were finally required.

(d) Cafés

Regular visits were paid to roadside transport cafés. In several instances it was necessary to call the occupiers attention to matters in order to comply with the Food and Drugs Act and the recently adopted byelaws relating to the handling and wrapping of food.

(e) Food Inspection

The following foods were condemned during the year :—

(a) Canned foods—

Evaporated Milk	28 tins
Imported Ham	5 tins (50 lbs.)

(b) Home killed meat—

	Cause of Condemnation	lbs.
Beef	Extensive Bruising ..	22
	Congestion ..	15
		37

(f) Adulteration

The Council is not a Food and Drugs Authority under the Food and Drugs Act, 1938.

(g) Food Poisoning Outbreaks

No cases came to the notice of the Council or were reported during the year.

ANDOVER RURAL DISTRICT COUNCIL

CHIEF SANITARY INSPECTOR'S REPORT FOR 1951

To the Chairman and Members of the Andover Rural District Council :

Ladies and Gentlemen,

I have the honour to present my Annual Report for the year ending 31st December, 1951.

HOUSING

It was not considered opportune or practicable during the year to commence any drastic action under the demolition or repair sections of the Housing Act, 1936.

Many of the cottages in the district cannot be repaired at reasonable expense to the owner due to the high costs of building repair work and to the absence of public sewers and water supplies. The only safe procedure in cases which merit such action, is the institution of demolition procedure under Section II of the Housing Act, in an endeavour to obtain a suitable undertaking from the owner until the houses can be satisfactorily repaired. This position does not, however, noticeably help the housing position. The cottages are usually sold or reconstructed to be let furnished at rentals outside the reach of the lower wage earning groups. It is often necessary to convert two and even three cottages into one to obtain satisfactory accommodation.

Many farmers have found it necessary to recondition their cottages to bring them up to a modern standard in order to attract labour. This voluntary action has been encouraged so far as the Building Licensing restrictions will allow.

No applications were made during the year for a grant under the Housing Act, 1949. Indeed, the cottages which could be brought up to a standard required within the ceiling of £600 and which will last for a period of 30 years are comparatively few and there are few farmers who will agree to " untie " their cottages in order to comply with the necessary grant conditions. The absence of piped water and sewerage systems is a considerable setback to progressive reconditioning in the villages.

New houses built during the year totalled 65 of which 56 were completed by the District Council and 9 by private enterprise.

52 houses were in course of erection by the Council at the end of the year.

There remained a total of 4 houses in which there were 15 family units, still under requisiton.

The properties under the control of this Council for housing purposes, were as follows :—

Permanent traditional houses (Pre-War Scheme)	156
Permanent traditional houses (Post-War Scheme) ..	319
Prefabricated temporary bungalows	32
Requisitioned Properties (family units)	15
Converted ex-service hutments	179
	701

From this it will be seen that, since the war a total of 545 family units have been provided and that with the applications on the Council's files, some 399 permanent houses are still required.

The condition of the hutted camps, and especially, of the corrugated iron Nissen type huts has deteriorated.

The roofs of this type of hut at Weyhill, Eastover, Grateley and South Tedworth were treated with hessian and bitumen during the summer, in an effort to prolong their life by ensuring resistance to weather penetration. This treatment does not however, provide against internal rusting, which is a serious matter and almost impossible to deal with.

The life of these huts is rapidly drawing to a close.

CONTROL OF CIVIL BUILDING

The control of civil building under Defence Regulation 56A continued without relaxation. Many applicants have had to wait considerable periods, in some cases over a year, before it has been found possible to issue licences. Unfortunately, the applicant, besides the delay, has had to contend with rapid increases in labour and material costs.

Licences were granted as follows :—

(a)	New Houses—Private Enterprise ..	7
(b)	Conversions and Adaptations	7
(c)	Other work	85

No applications were refused.

It was found necessary to send a warning letter to one contractor for contravening the Defence Regulation but no prosecution followed.

PLANS

Plans submitted for approval under the Council's Building Byelaws were as follows :—

Approved	102
Disapproved	2
Total	104

TOWN PLANNING

During the year, 130 development applications were dealt with by the County Council as follows :—

Applications	approved	108
,,	refused	15
,,	withdrawn ..	1
,,	permitted development	4
,,	pending	2
	Total	130

There were no appeals.

WATER SUPPLY

Samples of water for bacteriological examination taken during the year showed 246 as satisfactory, 47 not entirely satisfactory and 34 unsatisfactory.

It was found necessary to continue chlorination of the Faberstown and Appleshaw supplies and due to untraced slight intermittent pollution at Vernham Dean, a small chlorinator was put into operation.

It is known that 10 new boreholes were sunk in the district during the year.

In view of the possibility of a piped supply in the district, many persons having polluted water supplies at their premises which cannot be remedied except at excessive cost, are temporarily boiling all water at considerable inconvenience.

The preparation of the main scheme of water supply to most of the villages in the district proceeded satisfactorily during the year. The Ministry of Housing and Local Government enquiry was held on 21st November, 1951, at which the Ministry's Inspector, F. H. Seabrooke Esq. officiated. No decision was made known by the end of the year.

Work commenced in the autumn on the Bullington and Barton Stacey supply. This supply was a matter of urgency as many houses on the new War Department Housing Estate at Barton Stacey were nearing completion.

SEWERAGE AND SEWERAGE DISPOSAL

VALLEY OF THE PILL HILL BROOK

Some considerable time was spent in negotiating the sites for sewage pumping stations. Final settlements were made after some protracted negotiation and it was possible to inform the Ministry of Housing and Local Government to this effect. The Ministry required the advertisement of the proposals in view of the subsequent rate burden, and in addition, all Parish Councils concerned were informed. The Ministerial inquiry took place on 22nd November, 1951, but no decision had been made known by the end of the year.

SHIPTON BELLINGER

During the early part of the year, the possibility of the proposed scheme proceeding seemed remote, due to the inability to arrive at an agreement with the Laundry Company which will discharge a considerable volume of sewage.

A new approach produced a measure of agreement and by the end of the year, the outlook was optimistic. The Consulting Engineers are now preparing a detailed scheme.

FABERSTOWN

The constructional works were completed towards the end of the year and it was possible to inform owners that they could exercise their power under the Public Health Act, 1936, to connect their properties to the sewer. There are 40 dwelling houses concerned in the scheme.

HURSTBOURNE TARRANT

The further development of sewage proposals for this village is wholly dependent upon the progress made by the Kingsclere and Whitchurch R.D.C. It is understood that some difficulty has been encountered by that authority in the acquisition of a site for the sewage disposal works.

BARTON STACEY

Progress was made during the year in the preparation of a scheme for the sewerage of Barton Stacey. The proposal is to discharge the sewage from the village into the sewer provided by the War Department for the new Housing Site North East of the village. Due to the arrangement of houses and the provision of piped water supply in the village, sewerage is an urgent neccesity.

MOVABLE DWELLINGS

It has not been the policy of the Council to provide special sites for caravans but rather to consider sympathetically the applications of individuals when they have found a site suitable to themselves. In this respect, the Town Planning Authority have also shown sympathetic consideration to applicants. Most of the applications have been made by persons with modern caravans having every possible convenience. Most of the persons are not habitual caravan dwellers but have no satisfactory alternative to that mode of living. It is undoubtedly healthier than congested accommodation in rooms.

REFUSE COLLECTION AND SALVAGE

The weekly collection of refuse was maintained in the District. The volume of refuse and salvage has gradually increased and some modification of the system of collection, with increase in capacity of vehicles, was found necessary. It was decided therefore to obtain a new low-loading " Karrier " Bantam lorry and to operate a shuttle service until delivery of a larger " Karrier " Refuse Collecting vehicle could be obtained.

The " Fordson " vehicle, which was entirely unsuitable for the work, was therefore sold.

Considerable difficulty was experienced with inadequate or unsatisfactory labour and there were frequent changes which did harm to the efficiency of the service.

The amount of salvageable material collected and sold during 1951 was as follows :—

	Weight				**Value**		
	Tons	cwts	qrs.	lbs.	£	s.	d.
Baled paper and cardboard	81	1	0	2	1157	9	2
Bones		4	2	0	2	5	0
Rags and Sacking	4	3	2	20	126	4	5
Metals	14	5	2	9	95	12	3
Total	99	14	3	3			
Jars and bottles	761½ dozen			..	24	13	7
			Total	..	£1406	4	5

RODENT CONTROL

Rodent control has operated as a joint scheme under a Committee comprising members of the Rural District and Borough Councils.

The Borough Council gave notice that it was not satisfied with the arrangement and with effect from 30th September, 1951, the joint scheme ceased to function. The District Council therefore engaged two operators to investigate and destroy rats on repayment.

The new arrangement had not settled down satisfactorily at the end of the year, and it became obvious that some modification of the system was necessary, in order that both inspection work and destruction of rodents on private premises should be carried out as efficiently and expeditiously as possible.

I have the honour to be,

Ladies and Gentlemen

Your obedient servant,

R. J. RICHARDS,

Surveyor and Sanitary Inspector.